

Skin Lesions Template

The next template which is unique to the Nursing Home Suite of Templates is Skin Lesions. The full name of the template is “Clinically Unavoidable Skin Lesions.”

Skin lesions are common in long-term care facilities, and often are unavoidable. This template helps identify the patients who are at risk of unavoidable skin lesions.

The template is organized into three vertical sections.

The left-hand section has two columns.

Risk Factors – 22 conditions are listed which contribute to the patient’s being at risk for “Clinically Unavoidable Skin Lesions.” These should be reviewed and any risk factors which apply to the patient should be documented by checking the box next to it. These are in demographic fields, which means that once they are checked, they remain checked in subsequent visits until they are unchecked.

Clinically Unavoidable Skin Lesions

Risk Factors

- Severe COPD
- Diabetes
- Severe PVD
- Chr. Bowel Inc.
- Chr. Urinary Inc.
- Paraplegia
- HOB Increase
- Quadraplegia
- Sepsis
- Terminal Cancer
- Chr. ESRD
- Unable to turn and position
- Chr. ES Liver DX.
- Chr. ES Heart DX.
- Immunosuppression
- Full Body Cast
- Steroid Therapy
- Radiation Therapy
- Renal Dialysis
- Terminal Illness
- Bed Bound
- Comatose/Semicomatose due to medical condition

Skin Condition

- Poor skin turgor
- Muscle wasting
- Cachexia
- Calf tenderness
- Bilateral edema
- Reduced urinary output
- Weight loss (more than 5% in one month)
- History of healed decubitus
- Mobility
- Mental status

Laboratory Results (* may indicate malnutrition/dehydration)

MCV Serum Transferrin *(< 180 mg)

MCH Serum Albumin *(< 3.0 g/dl)

Hgb Total Protein *(< 5.1 g/dl)

Intervention

Skin Care

- Cleanse with Dial soap and water and rinse well
- Granules
- Panifil Ointment
- Bactoban Ointment
- TAO
- Accuzyme
- Other

Mobility

- Turn off affected area
- Do not get up in chair
- May be up for hours daily

Return

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-
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Risk Assessment

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Help Documents

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Laboratory Results –

There are six laboratory results here which impact the ability of the patient to heal wounds and/or which indicate the presence of chronic malnutrition which would prevent wound healing. There is a button entitled **Check for New Lab** which allows you to import the most recent lab values on this patient. Additional information on the patient’s nutritional status can be found on the Nutrition Template. To learn more about the Nutrition template, visit the [Nutrition](#) tutor. To

review the tests necessary to evaluate the patient’s nutritional status, see the **Lab Charge Posting** template

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Skin Condition

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- Calf tenderness
- Bilateral edema
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- Weight loss (more than 5% in one month)
- History of healed decubitus:
- Mobility
- Mental status

Laboratory Results (* may indicate malnutrition/dehydration) Check for New Labs

MCV	<input type="text" value="///"/>	Serum Transferrin	<input type="text" value="///"/>	*(< 180 mg)
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Intervention

Skin Care

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- Granules
- Panifil Ointment
- Bactoban Ointment
- TAO
- Accuzyme
- Other

Mobility

- Turn off affected area
- Do not get up in chair
- May be up for hours daily

Return

Risk Assessment

Help Documents

Intervention ---

This section addresses 6 skin-care options and 3 Mobility options for improving skin care. However, in the presence of the above mentioned Risk Factors and in the presence of clinically unavoidable malnutrition, maintaining the integrity of the skin is not possible.

Clinically Unavoidable Skin Lesions

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Intervention

Skin Care

- Cleanse with Dial soap and water and rinse well
- Granules
- Panifil Ointment
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- TAO
- Accuzyme
- Other

Mobility

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- Do not get up in chair
- May be up for hours daily

Risk Assessment

Help Documents

At the very bottom of this left-hand section is a button entitled **Care for Dry Skin**. When launched 8 options for caring for dry skin appear. There are boxes which allow the selecting of certain options which will then appear on the chart note.

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- Paraplegia
- HOB Increase
- Quadraplegia
- Sepsis
- Terminal Cancer
- Chr. ESRD
- Unable to turn and position

Laboratory Results (* may indicate malnutrition)

MCV //

MCH //

Hgb //

Intervention

Skin Care

- Cleanse with Dial soap and water
- Granules
- Panifil Ointment
- Bactoban Ointment
- TAO
- Accuzyme
- Other

Skin Condition

- Chr. ES Liver DX
- Chr. ES Heart DX
- Immunosuppressk
- Full Body Cast
- Steroid Therapy
- Radiation Therap
- Renal Dialysis
- Terminal Illness
- Bed Bound
- Comatose/Semic
- due to medical o

Poor skin integ

Return

Guides Dry Skin

Skin Care for Dry Skin

- Take fewer showers or baths (2 to 3 per week is fine). Keep them short and use warm, not hot, water
- Apply lotion over your whole body after you towel off
- Always apply lotion immediately after swimming or in a chlorinated pool or sitting spa
- Avoid saunas
- Apply lotion all over your body at bedtime
- Use soaps for designed for dry skin, such as glycering soap with cleansing cream, and rinse well
- Consider using a humidifier on cold, dry winter days
- Drink more fluids but avoid alcohol, spicy foods, and ceffeine

Do not get up in chair

May be up for hours daily

Middle Section of Clinically Unavoidable Skin Lesions Template

Skin Condition – this provides the opportunity to document 10 skin conditions which contribute to Clinically Unavoidable Skin Lesions.

Right-hand section of Clinically Unavoidable Skin Lesions Template

NH Master – this is a navigation button back to NH Master Template

Clinically Unavoidable Skin Lesions

Risk Factors

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Skin Condition

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- Reduced urinary output
- Weight loss (more than 5% in one month)
- History of healed decubitus:
- Mobility
- Mental status

Return

[Wound Protocol](#)

[Call to Family](#)

[Document](#)

Laboratory Results (* may indicate malnutrition/dehydration) [Check for New Labs](#)

MCV <input type="text" value="//"/>	Serum Transferrin <input type="text" value="//"/>	*(< 180 mg)
MCH <input type="text" value="//"/>	Serum Albumin <input type="text" value="//"/>	*(< 3.0 q/d)
Hgb <input type="text" value="//"/>	Total Protein <input type="text" value="//"/>	*(< 5.1 q/d)

Intervention

Skin Care

- Cleanse with Dial soap and water and rinse well
- Granules
- Panfil Ointment
- Bactoban Ointment
- TAO
- Accuzyme
- Other

[Care for Dry Skin](#)

Mobility

- Turn off affected area
- Do not get up in chair
- May be up for hours daily

Risk Assessment

[Waterlow Risk Assessment](#)

[Norton Risk Assessment](#)

[Braden Risk Assessment](#)

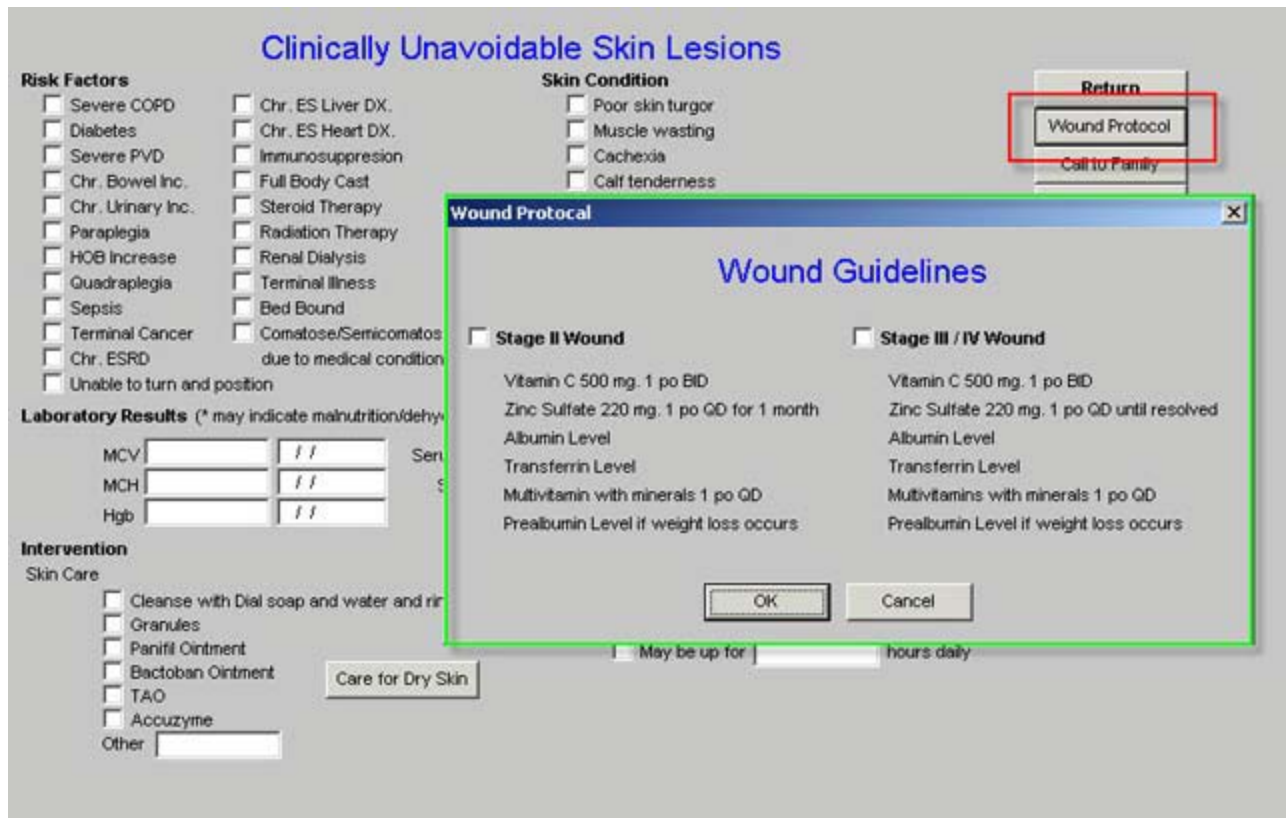
Help Documents

[Skin Care in Elderly Patients](#)

[Skin Integrity](#)

[Skin Care Glossary](#)

Wound Protocol – this launches the Wound Protocol pop-up which gives treatment guidelines for Stage II wounds and for Stage III/IV Wounds. This is a different guideline than that for the [Skin Tear Guidelines](#)



Call to Family – this launches the Call to Family Record. For details see below.
Document – this creates a document for the chart from the evaluation of **Clinically Unavoidable Skin Lesions**.

Beneath this are two functions

Risk Assessment

- **Waterlow Risk Assessment** -- this is a standardized risk assessment from 11 categories which indicates whether or not the patient has a clinically unavoidable skin lesion risk.

Waterlow Skin Lesion Prevention/Treatment Policy

Return

Build/Weight for Height

Average
 Above Average
 Obese
 Below Average

Sex

Male
 Female

Continence

Complete/Catheter
 Occasional Incontinence
 Catheter/Incontinence Feces
 Doubtly Incontinent

Age

14 - 49
 50 - 64
 65 - 74
 75 - 80
 > 81

Skin Type and Visual Risk Areas

Healthy
 Tissue Paper, Dry, Edematous, Clammy
 Discolored
 Broken

Tissue Malnutrition

Terminal Cachexia
 Cardiac Failure or Peripheral Vascular Disease
 Anemia
 Smoking

Mobility

Fully
 Restless/Fidgety
 Apathetic
 Restricted
 Traction
 Chair-Bound

Medication

Anti-Inflammatories, Steroids, or Cytotoxics
 None of the Above

Appetite

Average
 Poor
 NG Tube or Fluids Only
 NEM / Anorexia

Major Surgery/Trauma

Orthopaedic Below Waist, Spinal
 OR > 2 Hours

Neurological Deficit

Diabetes, CVA, MS, Paraplegia
 None of the Above

Score **Assessment**

Previous Results

Encounter Date/Time	Score	Assessment

- Norton Risk Assessment** – this is the Norton Risk Assessment Clinically Unavoidable Skin Lesions which assesses the patient from 5 categories. A score is produced and indicates the patient’s risk for clinically unavoidable skin lesions.

Norton Risk Assessment Clinically Unavoidable Skin Lesions

Return

Physical Condition

- Good
- Fair
- Poor
- Bad

Mental Condition

- Alert
- Apathetic
- Confused
- Stuporose

Activity

- Ambulant
- Walks with Help
- Chair-Bound
- Bed-Bound

Mobility

- Full
- Slightly Limited
- Very Limited
- Immobile

Incontinence

- Not
- Occasionally
- Usually of Urine
- Doubly

Score

A score less than 16 indicates patient at risk.

Previous Results *A score less than 16 indicates patient at risk.*

Encounter Date:Time	Score

- **Braden Risk Assessment** – Baden Scale Clinically Unavoidable Skin Lesions. This is based on 6 categories of evaluation and gives a score which indicates whether or not the patient is susceptible to clinically unavoidable skin lesions.

Braden Scale Clinically Unavoidable Skin Lesions

Return

Sensory Perception

- Completely Limited
- Very Limited
- Slightly Limited
- No Impairment

Skin Moisture

- Completely Moist
- Very Moist
- Occasionally Moist
- Rarely Moist

Activity

- Bedfast
- Chairfast
- Walks Occasionally
- Walks Frequently

Mobility

- Completely Immobile
- Very Limited
- Slightly Limited
- No Limitation

Nutrition

- Very Poor
- Probably Inadequate
- Adequate
- Excellent

Friction and Shear [Help](#)

- Problem
- Potential Problem
- No Apparent Problem

Score

Assessment

Previous Results

Encounter Date:Time	Score	Assessment
12/02/2009 08:29 AM	14	The patient has a high risk for developing clinically unavoidable skin lesions.

Note: On the **Braden Assessment** there is a pop-up entitled **Friction and Shear** which expands on this risk factor.

Braden Scale Clinically Unavoidable Skin Lesions

Sensory Perception

Completely Limited
 Very Limited
 Slightly Limited
 No Impairment

Skin Moisture

Completely Moist
 Very Moist
 Occasionally Moist
 Rarely Moist

Activity

Bedfast
 Chairfast
 Walks Occasionally
 Walks Frequently

Mobility

Completely Immobile
 Very Limited
 Slightly Limited
 No Limitation

Nutrition

Very Poor
 Probably Inadequate
 Adequate
 Excellent

Friction and Shear

Problem
 Potential Problem

Score Assessment

Previous Results

Encounter Date:Time	Score	Assessment
12/02/2009 08:29 AM	14	The patient has

Friction and Shear

Problem
Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction.

Potential Problem
Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slide down.

No Apparent Problem
Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair.

Help Documents

- **Skin Care in Elderly Patients** – this document gives more detail about skin care in the elderly.
- **Skin Integrity** – this is an excellent discussion with pictures of the integrity or lack of integrity of the skin.
- **Skin Care Glossary** – this defines 16 terms commonly used in evaluating the skin.

Clinically Unavoidable Skin Lesions

Risk Factors

- | | |
|--|--|
| <input type="checkbox"/> Severe COPD | <input type="checkbox"/> Chr. ES Liver DX. |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Chr. ES Heart DX. |
| <input type="checkbox"/> Severe PVD | <input type="checkbox"/> Immunosuppression |
| <input type="checkbox"/> Chr. Bowel Inc. | <input type="checkbox"/> Full Body Cast |
| <input type="checkbox"/> Chr. Urinary Inc. | <input type="checkbox"/> Steroid Therapy |
| <input type="checkbox"/> Paraplegia | <input type="checkbox"/> Radiation Therapy |
| <input type="checkbox"/> HOB Increase | <input type="checkbox"/> Renal Dialysis |
| <input type="checkbox"/> Quadraplegia | <input type="checkbox"/> Terminal illness |
| <input type="checkbox"/> Sepsis | <input type="checkbox"/> Bed Bound |
| <input type="checkbox"/> Terminal Cancer | <input type="checkbox"/> Comatose/Semicomatose
due to medical condition |
| <input type="checkbox"/> Chr. ESRD | |
| <input type="checkbox"/> Unable to turn and position | |

Skin Condition

- | |
|--|
| <input type="checkbox"/> Poor skin turgor |
| <input type="checkbox"/> Muscle wasting |
| <input type="checkbox"/> Cachexia |
| <input type="checkbox"/> Calf tenderness |
| <input type="checkbox"/> Bilateral edema |
| <input type="checkbox"/> Reduced urinary output |
| <input type="checkbox"/> Weight loss (more than 5% in one month) |
| <input type="checkbox"/> History of healed decubitus <input type="text" value="//"/> |
| <input type="checkbox"/> Mobility |
| <input type="checkbox"/> Mental status |

Return

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-
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Risk Assessment

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Laboratory Results (* may indicate malnutrition/dehydration)

MCV <input type="text" value="//"/>	Serum Transferrin <input type="text" value="//"/>	*(< 180 mg)
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Intervention

Skin Care

- Cleanse with Dial soap and water and rinse well
- Granules
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- TAO
- Accuzyme
- Other

Mobility

- Turn off affected area
- Do not get up in chair
- May be up for hours daily

Help Documents

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-